NATIONAL AUDIT OFFICE OF LITHUANIA
• BRINGING BENEFITS •

ASSESSMENT OF REGULARITY OF 2019 SETS OF CONSOLIDATED FINANCIAL AND BUDGET EXECUTION REPORTS AND LEGALITY OF MANAGEMENT, USE AND DISPOSAL OF FUNDS AND PROPERTY OF THE COMPULSORY HEALTH INSURANCE FUND

1 October 2020

No. FAE-5

SUMMARY

The Objective and Scope of the Audit

Pursuant to the Law on National Audit Office [1], and the Law on Public Sector Accountability[2], we have conducted the audit of the assessment of regularity of 2019 sets of consolidated financial and budget execution reports and legality of management, use and disposal of funds and property of the Compulsory Health Insurance Fund.

The audit has been performed in accordance with the Public Auditing Requirements, International Auditing Standards, and International Standards of Supreme Audit Institutions. The audit report includes only the matters performed and identified during the audit, and independent opinion on the sets of consolidated state financial and budget implementation reports are expressed in the audit opinion. The scope of the audit and the applied methods are described in more detail in Annex 2 “The Scope and Methods of the Audit” (pp. 26–28).

[1] Law on National Audit Office, Article 9, para 1, point 5

[2] Law on Public Sector Accountability, Article 30

Key Results of the Audit:

1. There were no material misstatements or compilation inconsistencies in the consolidated financial and budget execution reports for 2019

Consolidated financial and budget execution reports data for 2018 of the Compulsory Health Insurance Fund are prepared and presented, in all material respects, in accordance with the applicable requirements and give a true and fair view (Section 1, p. 11).

2. Costs of medical establishments to determine the price of services are not comparable

The funds of the personal health care services provided by medical establishments are paid according to the basic prices approved by the Ministry. Based on the prices and t the quantity of services planned to be provided to the insured, the amount, planned to be paid from the Fund to medical establishments for the provided personal health care services, is calculated each year.

The costs of medical establishments are assessed annually to determine the basic prices of active treatment services, therefore it is important to ensure the provision of correct data. The audit found that 70% of all the medical establishments audited incorrectly distribute the costs to the main and other activities, therefore false data are submitted to the National Health Insurance Fund to calculate and pay the fee for the provided treatment services.

The remuneration for the services provided is also influenced by one of the cost groups, i.e. depreciation and amortisation costs, which will double as of 01/11/2020 due to changes in the property management arrangements. These costs have been calculated on the basis of different and economically unreasonable rates:

- the medical establishments audited use between 9% and 75% of total depreciated property in their activities. This means that the depreciation costs of the property are unjustifiably increased at the beginning of its use and are unduly reduced in subsequent periods;
- Medical establishments, depending on their subordination to the Ministry of Health or municipalities set different depreciation (amortisation) rates of fixed assets. During the audit, we found that for this reason depreciation rates applied by the 20 medical establishments audited differ by up to 5 times in certain cases, the depreciation costs calculated by medical establishments differs accordingly;
- Medical establishments calculate depreciation and amortisation costs according to a directly proportionate (annual) depreciation method which does not take into account the intensity of equipment use. The results of the audit showed that the use intensity of more than half (59%) of the assessed expensive (over EUR 28 thousand) medical devices is low, 7% of them are not used at all.

Thus, incorrect allocation of costs and application of different and economically unreasonable depreciation rates enable to influence the amount of costs used for the

calculation of the price of personal health care services, the Fund's possibilities for the payment of personal health care services and assessment of the institution's performance (surplus/deficit) (Sub-section 2.1, pp. 11–15).

3. There are differences between regulation and practice of paid health care services

Under the current regulation, medical establishments of the national health system of Lithuania may provide paid personal and public health care services the list and prices of which are approved by the Ministry of Health, however the audit results showed that medical establishments approve and provide other paid medical services and at prices other than those established by the Ministry. It should be noted that the lists of paid medical services of the Ministry of Health for the inclusion of new services have not been changed for more than 10 years. In the spring of 2017, the Seimas has registered a draft law proposing to grant the right to the head of the medical establishment to approve the prices of medical services paid by patients.

With the development of medical technology and treatment methods, medical establishments cannot but focus on medical progress, yet, it is also important that all medical establishments apply the legislation governing the provision of paid personal health care in the same way, thus ensuring that patients have equal access to these services.

With a view to ensuring and constantly improving the quality of services, taking into account scientific and technological progress and equal access to services for patients, the Ministry of Health has to update the lists of paid medical services in due time and carry out control of the provision of services according to the lists (Sub-section 2.2, pp. 15–18).

4. Not all the funds allocated to raise the salaries of health care professionals have reached the target

The sectoral collective agreement, which was signed by the Ministry of Health on 31/08/2018, provided that, additional funds allocated by public institutions from the Fund to pay for personal health care services with a recommendation to direct them to increase the remuneration of health care professionals, must be used to increase the salaries. Having increased the basic prices of personal health care services paid from the budget of the Fund since 01/09/2019, the Compulsory Health Insurance Council recommended using all such additional funds (EUR 41.15 million) to increase the salaries of health care professionals. We note that the Fund pays medical institutions for the medical services provided, and medical establishments make decisions on the use of funds, including the increase in salaries.

Only about half of the 20 hospitals audited fully followed this recommendation. Other funds were also allocated to other costs related to the activities of medical establishments: payment of public utility services, purchase of medicines, medical supplies, etc.

Such decisions of medical establishments were influenced by lower (80–85%) target values for the use of these funds, approved by the Ministry, used to evaluate the activities of medical establishments. In addition, the National Health Insurance Fund and medical

establishments assessed differently what positions are attributed to health care professionals, what period of time the salaries should be assessed, and who should carry out assessments. As a result of these shortcomings, different results of the use of additional funds for increasing salaries were recorded.

Abstract rules, calculations based on different data show a lack of objectivity in the assessment of the activities of establishments and the use of additional funds allocated to increase salaries (Sub-section 2.3, pp. 18–21).

Recommendations

To the Ministry of Health

1. In order to ensure that the data provided by medical establishments to calculate the cost of health care services are correct and comparable, to develop a system ensuring the provision of such data (2 key audit result).

2. With a view to ensuring and continuously improving the accessibility and quality of services, taking into account scientific and technological progress, to develop measures to ensure the implementation of the functions established by law, namely, approving paid medical services and their prices: timely updating of the lists of paid medical services; control of the provision of services on the basis of the lists of paid medical services (3 key audit result).

The measures, deadlines, and indicators for the implementation of the Recommendations, according to which we will assess the situation, whether the implemented measures achieved the planned result and created the expected change, are presented in the Section “Recommendation Implementation Plan” of the report (pp. 22–23). During the audit, we also made a recommendation of lesser importance to the Ministry of Health: to improve the legislation regulating the establishment of the target indicator of the assessment of medical establishments. We will not apply change assessment indicators to assess this change; we will assess them according to the results of the implementation of the planned measures.

In order to move towards the price of personal health care services based on objective costs and periodically recalculated, to optimise the activities of the Fund, specify the purpose of contributions to the Fund and clearly define the scope of guaranteed services paid with funds and centralise the process of concluding contracts with medical establishments, it is important to implement the recommendations made during previous audits (public audit reports of the Fund: 30/09/2019 No FA-7, 01/10/2018 No FA-2018-P-6-3-7-1;29/09/2017 No FA-2017-P-10-10-4-1):

1. To improve legal regulation by establishing a clear scope of paid personal health services (health insurance contributions) and to envisage that health insurance contributions cover only those expenses which are in line with the purpose of insurance and are not to be covered with the State’s funds.

2. To initiate a discussion with the establishments responsible for Social Assistance Policy in order to assess the need for more extensive health care services provided to socially sensitive groups, its conformity to the content of social assistance, and to

initiate changes in legal regulation so that such social support is financed with funds other than the funds of compulsory health insurance contributions.

3. Following the implementation of recommendations of previous audits and being aware of the exact financial capabilities of the Fund, to move to personal health care prices that are based on objective costs and are periodically recalculated in accordance with set criteria.

4. Ensure that all instalments of the payment for personal health care services meet the provisions of the law.

5. Regulate the inclusion and exclusion of personal health care services as compensated via the fund in accordance with criteria set out in the law, having regard to the price of the provision of services and the objectively assessed capabilities of the Fund. Set the frequency of the update and revision of the list of compensated services (legal acts are approved, we are waiting for its practical implementation).

6. In order to optimise the fund and simplify its management structure, merge the six currently operational agencies responsible for the administration of the fund into a single legal entity.

7. In order to ensure that medical establishments operate in a uniform competitive environment and in order to reduce the administrative burden, to centralise the process of contracting with medical establishments.